City of Longview

1525 Broadway
Longview, WA 98632
www.ci.longview.wa.us

LEOFF-1
Disability Board

Agenda

Wednesday, April 24, 2024 | **8:30 AM** | **2nd Floor, City Hall**

The LEOFF-1 Disability Board meeting of April 24, 2024 will be held on the 1st floor of the City Hall in the Public Works - Community & Economic Development Conference Room.

The City Hall is accessible for persons with disabilities. Special equipment to assist the hearing impaired is also available. Please contact the City Executive Office at 360.442.5004 48 hours in advance if you require special accommodations to attend the meeting.

To attend the meeting virtually use the link or information below:
Click here to join the meeting
Meeting ID: 269 837 824 466
Passcode: 998pKy

Or call in (audio only)
+1 213-631-2692
Phone Conference ID: 315 649 02#

1 CALL TO ORDER

2 ROLL CALL

3 CHANGES TO THE AGENDA

4 PUBLIC COMMENT

5 APPROVAL OF MINUTES

24-00120 March 27, 2024 Regular Meeting Minutes

6 MEDICAL REIMBURSEMENT REQUESTS

24-00380 Request reimbursement for Dental work completed 2-15-2022 totaling $4,040.80

7 APPROVAL OF BILLS

24-00121 April 2024 Medicare B Reimbursement - Total $8,933.40

24-00122 April 2024 Medical Bills (Regular) - Total $12,403.39

8 NEW BUSINESS

9 ADJOURNMENT

NEXT REGULAR MEETING - Wednesday, May 29, 2024 at 8:30 a.m.

City of Longview

Agenda Summary

March 27, 2024 Regular Meeting Minutes

Attachments:
1. March 27, 2024 Regular Meeting Minutes

City of Longview

1525 Broadway
Longview, WA 98632
www.ci.longview.wa.us

LEOFF-1
Disability Board

Minutes

Wednesday, March 27, 2024 | **8:30 AM** | **2nd Floor, City Hall, Small Conference Room**

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Or call in (audio only)
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Phone Conference ID: 315 649 02#

1 CALL TO ORDER

Chair Barnd called the meeting to order at 8:33 a.m.

2 ROLL CALL

Present: Don Barnd, Police Retiree Representative
Jim Morkert, Fire Retiree Representative
Chet Makinster, Member-at-Large
Kalei LaFave, Alternate City Council Representative
Erik Halvorson, City Council Representative
Excused: MaryAlice Wallis, City Council Representative

Also Present: Tiffany Ostreim, Board Secretary
Dana Beck, Payroll Specialist
Jim Duscha, Interim City Manager
Dana Gigler, City Attorney

3 CHANGES TO THE AGENDA

Member Morkert requested New Business - Annual Election of Chairperson and Vice Chairperson be moved to the first order of business. Members concurred.

8 NEW BUSINESS

24-00137 Annual Election of Chairperson and Vice Chairperson per Rule 1 - General, Section 9 - Officers

Chair Barnd called for nominations for position of Chairperson.
Member Morkert nominated Member Halvorson to the position of Chairperson. There were no other nominations. Nominations were closed. Member Halvorson was unanimously elected Chair for the period of March 2024 - March 2025.

Chair Halvorson called for nominations for position of Vice Chairperson.
Member Morkert nominated Member Wallis to the position of Vice Chairperson. There were no other nominations. Nominations were closed. Member Wallis was unanimously elected Vice Chairperson for the period of March 2024 - March 2025.

4 PUBLIC COMMENT

None.

5 APPROVAL OF MINUTES

24-00119 February 28, 2024 Regular Meeting Minutes

A motion was made by Member Barnd, seconded by Member Morkert to approve the February 28, 2024 Regular Meeting Minutes. The motion carried unanimously.

6 MEDICAL REIMBURSEMENT REQUESTS

24-00298 R-22 Request for pre-approval of Long-Term Care (LTC) facility cost and reimbursement of LTC in-home care received since September, 2023.

The Board discussed the request for long-term care facility reimbursement and long-term in-home care reimbursement.

A motion was made by Member Morkert, seconded by Member Makinster to reimburse for in-home care, from September of 2023 to December, 2023 in the total amount of $3,993 as reasonable and medically necessary. The motion carried unanimously.

UNUM verbally denied long-term care costs. The family is in the process of getting another evaluation and resubmitting to UNUM.

A motion was made by Member Makinster, seconded by Member Morkert to reimburse for long term care costs in the amount of $17,358 and establish an agreement with the family that provides if UNUM approves the claim for LTC, the family will reimburse the city the amount approved. The motion carried unanimously.

AMENDMENT - UNUM approved long-term care coverage. The city did not pay out $17,358.

7 APPROVAL OF BILLS

24-00113 March 2024 Medicare B Reimbursement - Total $8,580.

A motion was made by Member Morkert, seconded by Member Barnd to approve the bills as presented, reasonable, and medically necessary. The motion carried unanimously.

24-00114 March 2024 Medical Bills (Regular) - Total $41,608.51 AMENDMENT - Total $24,250.51

A motion was made by Member Morkert, seconded by Member Barnd to approve the bills as presented, reasonable, and medically necessary. The motion carried unanimously.

9 ADJOURNMENT

With no further business to discuss, Chair Halvorson adjourned the meeting at 9:06 a.m.

Next Meeting

The next regular meeting of the LEOFF-1 Board is scheduled for Wednesday, April 24, 2024 at 8:30 a.m.

_____ _____

Erik Halvorson, Chair *Tiffany Ostreim, Board Secretary*

The City of Longview Washington

Memorandum

TO: **LEOFF-1 DISABILITY BOARD**

FROM: **DANA BECK, INTERIM LEOFF-1 ADMINISTRATOR**

SUBJECT: R-21 REQUEST REIMBURSEMENT FOR DENTAL WORK COMPLETED 02/15/2022 TOTALING $4040.80.

R-21 Originally submitted insufficient documentation 06/2022. Spoke to R-22 and informed them of documentation needed to complete claim. R-22 can in with documentation needed around 03/25/2024. Explained they were past the year limit on reimbursements. They requested I take this information to the Board for approval.

Action needed on this claim:
Board needs to decide to approve or deny dental claim.

Documents included for review:

1. Reasonable & Medically Necessary Services Form
2. Estimate
3. Statements of Account & Services
4. Delta Dental Explanation of Benefits
5. Cancelled check for payment

City of Longview

LEOFF-1

Reasonable and Medically Necessary Services

Completion of this form by the physician (or dentist) recommending treatment is required for the LEOFF-1 Disability Board to consider reimbursement requests for services not covered by insurance (dental, massage, acupuncture, etc). The retiree is responsible for submitting the form to the LEOFF-1 Disability Board with a completed claim form, invoice or estimate, explanation of benefits from insurance (denial of claim), & proof of payment. ***Procedures that are purely cosmetic and not medically necessary are not eligible for reimbursement. The City of Longview cannot pay providers directly – the retiree is responsible for making payment. Only procedures/services that are determined to be reasonable and medically necessary by the LEOFF-1 Board will be considered for reimbursement.***

PATIENT/RETIREE NAME: [redacted]

1. Name of physician/dentist and business/clinic address: Dr. Chad Kleven, Advanced Dental Services, 870 11th Ave. Longview, WA

2. Condition requiring treatment: Implant supported crowns to replace the missing teeth #4, 5 and 12.

3. Summary of recommended services: Full crowns on dental implants. 3 total crowns.

4. Are the recommended services purely cosmetic (yes/no): NO

5. Are the recommended services reasonable and medically necessary (yes/no): Yes

6. Explain why you determined that the recommended services are reasonable and medically necessary:
Teeth #4, 5 and 12 were extracted and dental implants will be used to support full crowns. This is needed to provide [redacted] adequate surface area to chew and for proper phonetics. ( )

7. Please provide the dates on which services were provided (if already provided):
N/A

8. If the treatment has not yet been provided, are there alternative treatment options? No

9. What are the approximate costs of alternative treatment, if applicable?

N/A

10. Explain why these alternative treatment options were not chosen:

N/A

I swear under penalty of perjury that the above statements are true.

Physician/Dentist Signature

2/16/2022
Date

Patient/retiree authorization for the release of this form to the City of Longview LEOFF-1 Disability Board (Board Secretary Kaylee Cody):

[redacted]
Patient/Retiree Signature

2-16-22
Date

City of Longview

LEOFF-1

Reasonable and Medically Necessary Services

Completion of this form by the physician (or dentist) recommending treatment is required for the LEOFF-1 Disability Board to consider reimbursement requests for services not covered by insurance (dental, massage, acupuncture, etc). The retiree is responsible for submitting the form to the LEOFF-1 Disability Board with a completed claim form, invoice or estimate, explanation of benefits from insurance (denial of claim), & proof of payment. ***Procedures that are purely cosmetic and not medically necessary are not eligible for reimbursement. The City of Longview cannot pay providers directly – the retiree is responsible for making payment. Only procedures/services that are determined to be reasonable and medically necessary by the LEOFF-1 Board will be considered for reimbursement.***

PATIENT/RETIREE NAME: [redacted] LPD/LEFF I

1. Name of physician/dentist and business/clinic address: Cabel A. McDonald - Longview Oral Surgery -

2. Condition requiring treatment: #12 tooth Implant w/ Bone grafting and IV SED

3. Summary of recommended services: Implant #12 w/ Bone grafting and IV SED -

4. Are the recommended services purely cosmetic (yes/no): NO

5. Are the recommended services reasonable and medically necessary (yes/no): Yes!

6. Explain why you determined that the recommended services are reasonable and medically necessary:
Missing tooth #12

7. Please provide the dates on which services were provided (if already provided):
02/15/22 - surgery helt 3/31/22

8. If the treatment has not yet been provided, are there alternative treatment options? none

9. What are the approximate costs of alternative treatment, if applicable?

No other alternative treatment available -

10. Explain why these alternative treatment options were not chosen:

No other alternative treatment was available

I swear under penalty of perjury that the above statements are true.

Physician/Dentist Signature — Date: 2/16/2022

Patient/retiree authorization for the release of this form to the City of Longview LEOFF-1 Disability Board (Board Secretary Kaylee Cody):

Patient/Retiree Signature — Date: 2-16-22

Image Name: #12,BG,4,5

The Oral Maxillofacial Surgery Offices of:

Cabel A. McDonald DDS PLLC

& Associates

[redacted]

February 15, 2022

The following is an estimation of your recommended treatment based on verification with your insurance company. Estimated insurance benefits are listed below. This estimate is not a guarantee of payment from your insurance company. If you have any questions regarding the following information, please call the office at (360)425-7220.

Description	Th#	Fee	Write-off	Allowed	Insurance	Balance	
Detailed/Extensive Oral Evaluation		186.00	-54.00	132.00	132.00	0.00	
Cone Beam Ct Capture		162.00	-0.00	162.00	0.00	162.00	
Total for no phase		**348.00**	**-54.00**	**294.00**	**132.00**	**162.00**	
Gen Anesthesia First 15 Min		210.00	-32.00	178.00	102.40	75.60	*
Gen Anesthesia Add 15 Min		210.00	-32.00	178.00	142.40	35.60	
Gen Anesthesia Add 15 Min		210.00	-32.00	178.00	142.40	35.60	
Gen Anesthesia Add 15 Min		210.00	-32.00	178.00	142.40	35.60	
Endosseous Implant	12	2,504.00	-498.00	2,006.00	1,203.60	802.40	
X-Rays First Periapical	12	42.00	-17.00	25.00	25.00	0.00	
X-Rays Each Additional Film	12	31.00	-13.00	18.00	18.00	0.00	
Bone Graft Ridge Augmentation	UR	3,056.00	-0.00	3,056.00	0.00	3,056.00	
Total for Phase One		**6,473.00**	**-656.00**	**5,817.00**	**1,776.20**	**4,040.80**	
Cone Beam Ct Capture		162.00	-0.00	162.00	0.00	162.00	
Surgical Stent		325.00	0.00	325.00	0.00	325.00	
Total for Phase Two		**487.00**	**0.00**	**487.00**	**0.00**	**487.00**	
Gen Anesthesia First 15 Min		210.00	-32.00	178.00	142.40	35.60	
Gen Anesthesia Add 15 Min		210.00	-32.00	178.00	142.40	35.60	
Gen Anesthesia Add 15 Min		210.00	-32.00	178.00	142.40	35.60	
Gen Anesthesia Add 15 Min		210.00	-32.00	178.00	142.40	35.60	
Endosseous Implant	4	2,504.00	-498.00	2,006.00	22.20	1,983.80	†
X-Rays First Periapical	4	42.00	-17.00	25.00	0.00	25.00	†
X-Rays Each Additional Film	4	31.00	-13.00	18.00	0.00	18.00	†
Endosseous Implant	5	2,504.00	-498.00	2,006.00	0.00	2,006.00	†
X-Rays Each Additional Film	5	31.00	-13.00	18.00	0.00	18.00	†
X-Rays Each Additional Film	5	31.00	-13.00	18.00	0.00	18.00	†

Insurance may cover

Description	Th#	Fee	Write-off	Allowed	Insurance	Balance	
Uncover Implant	12	0.00	0.00	0.00	0.00	0.00	
X-Rays Each Additional Film	12	31.00	-13.00	18.00	0.00	18.00	†
Total for Phase Three		**6,014.00**	**-1,193.00**	**4,821.00**	**591.80**	**4,229.20**	
X-Rays First Periapical	4	42.00	-17.00	25.00	0.00	25.00	†
Uncover Implant	4	0.00	0.00	0.00	0.00	0.00	
X-Rays Each Additional Film	5	31.00	-13.00	18.00	0.00	18.00	†
Uncover Implant	5	0.00	0.00	0.00	0.00	0.00	
Total for Phase Four		**73.00**	**-30.00**	**43.00**	**0.00**	**43.00**	
Total		**13,395.00**	**-1,933.00**	**11,462.00**	**2,500.00**	**8,962.00**	

* $50.00 deductible applied † $2,500.00 annual maximum applied

Total fee for above procedures: $11,462.00

Your insurance company may pay: $2,500.00

In which case you would pay: $8,962.00

BALANCE DUE THE DAY OF SURGERY

Maximum allowable benefits for current year = $2,500.00

Payments already paid to date = $0.00

Remaining balance for this year = $2,500.00

- The estimated insurance payment may be reduced due to any pending dental claims not yet processed by your dental carrier.
- We cannot guarantee any payment from the insurance company.
- Accounts with no payment for 90 days will be referred to collections.

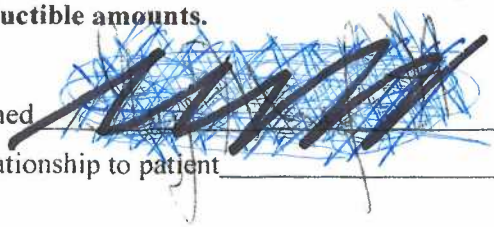
REQUEST FOR PREDETERMINATION

_____I **DO NOT** request a predetermination and understand the above fees are an estimate only.

_____I **REQUEST** a predetermination to get an estimate of fees directly from the insurance company. I understand this can take **45** days or more for a response. I also understand that if we get a predetermination from the insurance most insurance companies do not guarantee payment based on that predetermination.

The crown(s) for your implant(s) will be a separate fee billed by your dentist.

By signing below, I understand that this is my estimated co-pay amount and that I will be responsible for any denied and/or downgraded charges, lower allowable amounts or deductible amounts.

Signed  Date February 15, 2022

Relationship to patient _____

The Oral Maxillofacial Surgery Offices of:

Cabel A. McDonald DDS PLLC

& Associates

INSURANCE FINANCIAL POLICY

I have read and received a copy of the treatment plan and understand that it is only an estimate of my insurance benefits.

I understand that I am responsible for all charges resulting from treatment provided by Dr. Cabel A. McDonald and Associates.

As a courtesy, we will submit insurance claims for you. It is important to understand, that the contract regarding your dental/medical benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. Any balance that remains following insurance payment is due upon receipt of first monthly statement.

Treatment plan fees are subject to change after 6 months.

I accept terms & conditions stated above:

Patient Name: _____

Signature: _____ Date: 2-15-2022

Relationship to patient: _____

STATEMENT OF ACCOUNT

Activity 11/1/2022

Date	Patient	Dr	Claim	Th#	Description	Amount	Patient Responsibility
05/09/21					BALANCE FORWARD	711.80	711.80
05/14/21			CM81206 Dental		Primary Payment from Delta Dental of Washington	-489.80	-489.80
05/14/21			CM81206 Dental		REDUCE BALANCE DELTA WRITE OFFS	-222.00	-222.00
11/08/21			CM84733		LIMITED EVALUATION	90.00	
11/11/21			CM84733 Dental		Primary Payment from Delta Dental of Washington	0.00	
11/11/21			CM84733 Dental		REDUCE BALANCE DELTA WRITE OFFS	-5.00	
					NOT COVERED BY INSURANCE		85.00
11/08/21			CM		PAYMENT - CREDIT CARD, THANK YOU	-133.80	-133.80
11/09/21			CM84760	12	SURGICAL REMOVAL RESIDUAL ROOTS	371.00	
11/18/21			CM84760 Dental		Primary Payment from Delta Dental of Washington	-195.20	
11/18/21			CM84760 Dental		REDUCE BALANCE DELTA WRITE OFFS	-127.00	
					NOT COVERED BY INSURANCE		48.80
11/23/21			CM		Post Op	0.00	0.00
02/15/22			CM86777		DETAILED/EXTENSIVE ORAL EVALUATION	186.00	
02/15/22			CM86777		CONE BEAM CT CAPTURE	162.00	
					CONTINUED ON NEXT PAGE		

ACCOUNT STATUS

Longview Oral &Maxillofacial Surgery

Current	Over 30	Over 60	Over 90	Over 120	Last Payment Date	Year to Date Payments	Balance	Amount Due
0.00	144.00	0.00	0.00	0.00	8/29/2022	4,220.80	144.00	144.00

INSURANCE CLAIMS

Service	Submitted	Patient	Dr	Claim	Insurance Company	Type	Amount

Please call with any questions

Please detach and return this portion of statement with payment

AMOUNT ENCLOSED	Amount Due
	144.00

Remit by	Invoice Number	Account Number
11/11/2022	13884	124676

Accounts over 90 days past due will be charged a finance charge of 1.0% per month, which is an annual rate of 12.00%. A minimum of $0.50 per month will be charged. Accounts with no payment for 90 days will be referred tp collections.

Visa__MC__Acct#_____Exp.Date_____

Signature_____Amount_____

(360) 425-7220

[redacted]

Longview Oral &Maxillofacial Surgery
Cabel A. McDonald, DDS
855 11th Avenue, Suite B
Longview WA 98632

STATEMENT OF ACCOUNT

Activity 11/1/2022

Date	Patient	Dr	Claim	Th#	Description	Amount	Patient Responsibility
03/03/22	[redacted]		CM86777 Dental		Primary Payment from Delta Dental of Washington	-294.00	
03/03/22	[redacted]		CM86777 Dental		REDUCE BALANCE DELTA WRITE OFFS	-54.00	
02/15/22	[redacted]		CM		PAYMENT - CREDIT CARD, THANK YOU	-162.00	-162.00
03/31/22	[redacted]		CM88030		GEN ANESTHESIA FIRST 15 MIN	210.00	
03/31/22	[redacted]		CM88030		GEN ANESTHESIA ADD 15 MIN	210.00	
03/31/22	[redacted]		CM88030		GEN ANESTHESIA ADD 15 MIN	210.00	
03/31/22	[redacted]		CM88030		GEN ANESTHESIA ADD 15 MIN	210.00	
03/31/22	[redacted]		CM88030	12	ENDOSSEOUS IMPLANT	2,504.00	
03/31/22	[redacted]		CM88030	12	X-RAYS FIRST PERIAPICAL	42.00	
03/31/22	[redacted]		CM88030	12	X-RAYS EACH ADDITIONAL FILM	31.00	
03/31/22	[redacted]		CM88030	UR	BONE GRAFT RIDGE AUGMENTATION	3,056.00	
04/07/22	[redacted]		CM88030 Dental		Primary Payment from Delta Dental of Washington	-1,776.20	
04/07/22	[redacted]		CM88030 Dental		REDUCE BALANCE DELTA WRITE OFFS	-656.00	
					NOT COVERED BY INSURANCE		4,040.80
03/31/22	[redacted]		CM		PAYMENT - PRIVATE PAYMENT-CHECK	-3,878.80	-3,878.80
04/14/22	[redacted]		CM		Post Op	0.00	0.00
07/05/22	[redacted]		CM90113		CONE BEAM CT CAPTURE	162.00	

CONTINUED ON NEXT PAGE

ACCOUNT STATUS

Longview Oral &Maxillofacial Surgery

Current	Over 30	Over 60	Over 90	Over 120	Last Payment Date	Year to Date Payments	Balance	Amount Due
0.00	144.00	0.00	0.00	0.00	8/29/2022	4,220.80	144.00	144.00

INSURANCE CLAIMS

Service	Submitted	Patient	Dr	Claim	Insurance Company	Type	Amount

Please call with any questions

Please detach and return this portion of statement with payment

AMOUNT ENCLOSED	Amount Due
	144.00

Remit by	Invoice Number	Account Number
11/11/2022	13884	124676

Accounts over 90 days past due will be charged a finance charge of 1.0% per month, which is an annual rate of 12.00%. A minimum of $0.50 per month will be charged. Accounts with no payment for 90 days will be referred tp collections.

Visa__MC__Acct#_____Exp.Date_____

Signature_____Amount_____

(360) 425-7220

[redacted]

Longview Oral &Maxillofacial Surgery
Cabel A. McDonald, DDS
855 11th Avenue, Suite B
Longview WA 98632

STATEMENT OF ACCOUNT

Activity 11/1/2022

Date	Patient	Dr	Claim	Th#	Description	Amount	Patient Responsibility
07/07/22	[redacted]		CM90113 Dental		Primary Payment from Delta Dental of Washington	0.00	
					NOT COVERED BY INSURANCE		162.00
07/05/22	[redacted]		CM		PAYMENT - CREDIT CARD, THANK YOU	-162.00	-162.00
08/29/22	[redacted]		CM		PAYMENT - CREDIT CARD, THANK YOU	-18.00	-18.00
08/29/22	[redacted]		CM		Post Op	0.00	0.00
08/29/22	[redacted]		CM		Cancelled Appointment	0.00	0.00
09/26/22	[redacted]		CM91887		CONE BEAM CT CAPTURE	162.00	
09/29/22	[redacted]		CM91887 Dental		Primary Payment from Delta Dental of Washington	0.00	
					NOT COVERED BY INSURANCE		162.00

ACCOUNT STATUS

Longview Oral &Maxillofacial Surgery

Current	Over 30	Over 60	Over 90	Over 120	Last Payment Date	Year to Date Payments	Balance	Amount Due
0.00	144.00	0.00	0.00	0.00	8/29/2022	4,220.80	144.00	144.00

INSURANCE CLAIMS

Service	Submitted	Patient	Dr	Claim	Insurance Company	Type	Amount

Please call with any questions

Please detach and return this portion of statement with payment

AMOUNT ENCLOSED	Amount Due
	144.00

Remit by	Invoice Number	Account Number
11/11/2022	13884	124676

Accounts over 90 days past due will be charged a finance charge of 1.0% per month, which is an annual rate of 12.00%. A minimum of $0.50 per month will be charged. Accounts with no payment for 90 days will be referred tp collections.

Visa__MC__Acct#_____Exp.Date_____

Signature_____Amount_____

(360) 425-7220

[redacted]

Longview Oral &Maxillofacial Surgery
Cabel A. McDonald, DDS
855 11th Avenue, Suite B
Longview WA 98632

SAVE FOR KAYLEE -

STATEMENT OF SERVICES

Date	Name	Dr	Code	Description	Th / Surface Check #	Amount	Balance
2/15/2022	[redacted]	CM	0004.2	PAYMENT - CREDIT CARD, THANK YOU		-162.00	-162.00

Balance	Current	Over 30	Over 60	Over 90	Over 120	2022 Payments
-162.00	-162.00	0.00	0.00	0.00	0.00	162.00

Account Information

[redacted]

Account # 124676
Home [redacted]
Mobile [redacted]

Last Billing 8/31/2018
Last Private Payment 2/15/2022
Budget 0.00

Thank you!

Provider	Billing Date
Cabel A. McDonald DDS 855 11th Ave, Suite B Longview, WA 98632 360-425-7220	2/15/2022

Patient	Next Appointment Date	Time	Reason

Page 1 of 1

STATEMENT OF SERVICES

Date	Name	Dr	Code	Description	Th / Surface Check #	Amount	Balance
3/30/2022				BALANCE FORWARD		-162.00	-162.00
3/31/2022	[redacted]	CM	0010	PAYMENT - PRIVATE PAYMENT-CHECK	695	-3878.80	-4040.80

Balance	Current	Over 30	Over 60	Over 90	Over 120	2022 Payments
-4040.80	-4040.80	0.00	0.00	0.00	0.00	4040.80

Account Information

[redacted]

Account # 124676

[redacted]

Last Billing	8/31/2018
Last Private Payment	3/31/2022
Budget	0.00

Thank you!

Provider		Billing Date
Cabel A. McDonald DDS 855 11th Ave, Suite B Longview, WA 98632	360-425-7220	3/31/2022

Patient	Next Appointment Date	Time	Reason
[redacted]	Thursday, April 14, 2022	9:00 AM	Post Op

Page 1 of 1

DELTA DENTAL

Delta Dental of Washington
PO Box 75983 | Seattle, WA 98175-0983

Welcome

Here's Your Explanation of Benefits

Forwarding Service Requested

**********ALL FOR AADC 970
PB-DSM-1A-ENV 1490 9
[redacted]

THIS IS NOT A BILL

Patient Name [redacted]
Member ID [redacted]
Group ID [redacted]

For the Period: 02/15/2022 through 03/31/2022

The claim information listed here reflects dental claims for this date range.

Dear [redacted]

This Explanation of Benefits is a summary of recent dental office visits and treatments. It shows how much of the plan benefits were applied, how much is left to use, and if there are any expected out-of-pocket charges from the dentist.

Save a tree, save yourself the wait. Activate your MySmile® account to choose "paperless communications". Reduce your carbon footprint AND get your EOBs faster. Visit: DeltaDentalWA.com/mysmile

Total Billed	Other Insurance	Your Share	Network Savings
$7,139.00	$0.00	$4,040.80	$817.00

Claim # 202204731291100 **Service Provided By** CABEL MCDONALD **Claim Paid Date** 03/03/22

Claim Notes	Service	Service Date	Amount Billed	Network Discount	Deductible Applied	Paid By Your Dental Plan	Your Share
	Ext Oral Eval	02/15/22	$186.00	$54.00	$0.00	$132.00	$0.00
	Cone beam-U/L	02/15/22	$162.00	$0.00	$0.00	$162.00	$0.00
TOTAL			**$348.00**	**$54.00**	**$0.00**	**$294.00**	**$0.00**

Claim # 202208430600600 **Service Provided By** CHAD KLEVEN **Claim Paid Date** 03/31/22

Claim Notes	Service	Service Date	Amount Billed	Network Discount	Deductible Applied	Paid By Your Dental Plan	Your Share
	Limit Oral Eval	03/24/22	$90.00	$43.00	$0.00	$47.00	$0.00
	Fluoride Vrnsh	03/24/22	$49.00	$6.00	$0.00	$43.00	$0.00
	Perio Maint	03/24/22	$179.00	$58.00	$0.00	$121.00	$0.00
TOTAL			**$318.00**	**$107.00**	**$0.00**	**$211.00**	**$0.00**

Claim # 202209130386200 **Service Provided By** CABEL MCDONALD **Claim Paid Date** 04/07/22

Claim Notes	Service	Service Date	Amount Billed	Network Discount	Deductible Applied	Paid By Your Dental Plan	Your Share
	Gen Anes-Fst 15	03/31/22	$210.00	$32.00	$50.00	$102.40	$75.60
	Gen Anes-15 min	03/31/22	$210.00	$32.00	$0.00	$142.40	$35.60
	Gen Anes-15 min	03/31/22	$210.00	$32.00	$0.00	$142.40	$35.60
	Gen Anes-15 min	03/31/22	$210.00	$32.00	$0.00	$142.40	$35.60
	Surgcl Implant	03/31/22	$2,504.00	$498.00	$0.00	$1,203.60	$802.40
	Image-1st PA	03/31/22	$42.00	$17.00	$0.00	$25.00	$0.00
	Image-Addl PA	03/31/22	$31.00	$13.00	$0.00	$18.00	$0.00

Benefit Period Maximum Remaining: $0.00

Claim # 202209130386200 **Service Provided By** CABEL MCDONALD **Claim Paid Date** 04/07/22

Claim Notes	Service	Service Date	Amount Billed	Network Discount	Deductible Applied	Paid By Your Dental Plan	Your Share
1	Osseous Gft U/L	03/31/22	$3,056.00	$0.00	$0.00	$0.00	$3,056.00
TOTAL			**$6,473.00**	**$656.00**	**$50.00**	**$1,776.20**	**$4,040.80**

Have a Question? Contact Customer Service via:

Text: 833-604-1246

Call: 1-800-554-1907

Claim Notes:

1 This procedure is not a contract benefit. It is a contract exclusion. The cost is the patient's responsibility.

If you have questions or concerns about the actions of your insurance company or agent, or would like information on your rights to file an appeal, contact the Washington state Office of the Insurance Commissioner's consumer protection hotline at 1-800-562-6900 or visit www.insurance.wa.gov. The insurance commissioner protects and educates insurance consumers, advances the public interest, and provides fair and efficient regulation of the insurance industry.

YOUR BENEFITS SUMMARY | Benefit Period: 01/01/2022 - 12/31/2022

	paid-to date	*annual*
Deductible	$50.00	$50.00
Family Deductible	$50.00	$150.00
Maximum	$1,733.20	$2,500.00
Diagnostic/Preventive Services	$0.00	Unlimited
TMJ Maximum	$0.00	$1,000.00
	paid-to date	*lifetime*
TMJ Maximum	$0.00	$5,000.00

Benefit Period Maximum Remaining: $766.80

Benefit Period Maximum Remaining: $0.00

19-7076
3250 40024

DATE 3/3/22

PAY TO THE ORDER OF LOANS $ 3,878.80

Three thousand eight hundred seventy eight 80/100 DOLLARS

CHASE
JPMorgan Chase Bank, N.A.
www.Chase.com

MEMO #12 IMPLANT + BONE GRAFT

City of Longview

Agenda Summary

April 2024 Medicare B Reimbursement - Total $8,933.40

Attachments:
1. Medicare B April 2024 voucher list

Medicare Premiums April 2024

Code	Vendor #	Year	
R59	000092	2024	$508.00
R2	000122	2024	$257.50
R5	000233	2024	$382.70
R6	000278	2024	$174.70
R34	000447	2024	$164.70
R8	000465	2024	$174.70
R9	000466	2024	$174.70
R11	000632	2024	$174.70
R28	000664	2024	$174.70
R13	000666	2024	$174.70
R37	000701	2024	$0.00
R14	000706	2024	$174.70
R39	000740	2024	$174.70
R40	000744	2024	$174.70
R16	000789	2023	$164.90
R17	000827	2024	$174.70
R64	000883	2023	$204.10
R19	000963	2024	$174.70
R44	001021	2023	$164.90
R51	001106	2024	$170.70
R29	001124	2024	$174.70
R47	001226	2024	$174.70
R21	001245	2024	$174.70
R49	001402	2024	$174.70
R50	001481	2024	$159.70
R23	001511	2024	$174.70
R24	001631	2024	$174.70
R25	001644	2022	$256.10
R53	001685	Quarterly	$524.10
R63	001694	2024	$174.70
R55	001714	2024	$174.70
R56	001732	2024	$174.70
R58	001823	2024	$174.70
R26	002066	2024	$174.70
R27	210058	2024	$174.70
R18	210122	2023	$174.70
R42	210489	2023	$0.00
R48	211292	Quarterly	$0.00
R12	211809	2024	$257.50
R43	216727	2023	$174.70
R38	217404	2024	$174.70
R31	218105	2024	$147.70
R33	218134	2022	$164.90
R46	218350	2024	$174.70
R41	223804	2023	$164.90
R61	224982	2024	$174.70
R22	225194	2024	$174.70
R15	226325	2023	$174.70
			$8,933.40

City of Longview

Agenda Summary

April 2024 Medical Bills (Regular) - Total $12,403.39

Attachments:
1. Reimbursment April 2024 Spreadsheet

April 2024MEDICAL BILLS (Regular)			
Member	**Dental**	**Regular**	
R-05		$51.99	
R-13		$3,481.00	hearing aids approved 2/28/24
R-21	$636.40		
R-38		$7,392.00	
R-43		$270.00	
R-63		$572.00	
TOTAL	$636.40	$11,766.99	$12,403.39